NICOLE J. RAFANELLO, PH.D.
CLINICAL & FORENSIC PSYCHOLOGICAL CONSULTING SERVICES (CFPCS, LLC)
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NJ License #: 4972 / DC License #: PSY1000401

ADULT ASSESSMENT & REGISTRATION FORM

Today's date:

CLIENT INFORMATION

Last Name: | First Name: | Middle:

Is this your legal name? ❑ Yes ❑ No | Nicknames: | ❑Miss ❑Ms. ❑Mrs. ❑Mr. | Birth date: / / | Age: | Sex: ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Place of birth | Where did you grow up: | Handedness ❑ Right ❑Left ❑Both

Native Language: | Other Language(s) You Speak Fluently:

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Street address:

City: | State: | Zip: | Country

Home phone: Ok to Call? Yes ❑ No ❑ | Cell phone: Ok to Call? Yes ❑ No ❑ | Best Time to Call: * (see below)

* Calls will be discrete, please list any restrictions

E-mail address? ❑ Ok to send email communications? Yes ❑ No ❑

WHO REFERRED YOU? ☐ Dr. ☐ Hospital ☐ Family ☐ Friend ☐ Internet ☐ Other

May I have permission to thank this person for your referral ☐ Yes ☐ No | If yes, please list name and contact info below

First Name: | Last Name:

Street Address:

City: | State: | Zip:

Phone: | Email:

THIS IS A STRICTLY CONFIDENTIAL PATIENT MEDICAL RECORD. THE LAW STRICTLY PROHIBITS REDISCLOSURE OR TRANSFER WITHOUT PATIENT CONSENT. IT IS TO BE USED TO GUIDE AND FACILITATE THE ASSESSMENT CONDUCTED BY DR. RAFANELLO ONLY, UNLESS EXPRESS RELEASE IS GIVEN BY PATIENT.

Name: DOB:

EDUCATION					
	FROM - TO	SCHOOL NAME	SPECIAL CLASSES	ADJUSTMENT TO SCHOOL	DID YOU GRADUATE/ HIGHEST DEGREE
ELEMENTARY					
HIGH SCHOOL					
VOCATIONAL / TRADE					
COLLEGE					
GRADUATE					

Please describe any additional information regarding your education history which you think would be helpful:

____

____

____

OCCUPATION / EMPLOYMENT INFORMATION	
CHECK ALL THAT APPLY – ARE YOU CURRENLTY: ❑ EMPLOYED ❑ SELF-EMPLOYED ❑ UNEMPLOYED ❑ RETIRED ❑ STUDENT ❑ HOMEMAKER ❑ ON DISABILITY ❑ ON LEAVE ❑ OTHER	
IF EMPLOYED - NAME OF EMPLOYER	DATE STARTED:
JOB TITLE OR DUTIES:	ADJUSTMENT TO JOB/PROBLEMS?
IF SELF EMPLOYED - NATURE OF BUSINESS OR SERVICES PROVIDED:	

Please describe any additional information regarding your occupation or employment history which you think would be helpful:

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Name: DOB:

MILITARY SERVICE INFORMATION						
ENTERED INTO SERVICE		SERVICE NUMBER	SEPERATED FROM SERVICE		BRANCH OF SERVICE	GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

FAMILY OF ORIGIN HISTORY					
NAME	CURRENT AGE OR DATE DECEASED	ILLNESSES OR CAUSE OF DEATH IF DECEASED	HIGHEST LEVEL OF EDUCATION	OCCUPATION	MAY I CONTACT THIS PERSON (YES/NO)
MOTHER					
FATHER					
WERE YOU RAISED BY: ☐ONE PARENT ☐BOTH PARENTS ☐ADOPTVE PARENTS ☐GUARDIANS ☐RELATIVES ☐OTHER:					
HOW MANY SIBLINGS DO YOU HAVE:			YOUR BIRTH ORDER:		
BESIDES YOUR PARENTAL CARETAKERS OR SIBLINGS, WERE THERE OTHER ADULTS LIVING IN THE HOUSE YOU GREW UP IN? ☐YES ☐NO If Yes, were they: ☐Grandparents ☐Other Relatives ☐Family Friends ☐Renters/Lodgers ☐Other					

MARITAL HISTORY					
	NAME	SPOUSE'S AGE AT TIME OF MARRIAGE / YOUR AGE AT TIME OF MARRIAGE	YOUR AGE AT TIME OF DIVORCE / WIDOWED OR NOT APPLICABLE	REASON FOR ENDING	MAY I CONTACT THIS PERSON? (YES/NO)
1ST		/			
2ND		/			
3RD		/			

CHILDREN					
	NAME / SEX	CURRENT AGE	YOUR AGE WHEN CHILD WAS BORN	SCHOOL & GRADE / OCCUPATION	MAY I CONTACT THIS PERSON (YES/NO)
1ST					
2ND					
3RD					
4TH					
5TH					

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Name: DOB:

MEDICAL CARE & HISTORY

Month and year of your last physical?	Any new problems or major findings?

Are you currently being treated by a doctor or taking medications prescribed by a doctor? ☐ Yes ☐ No

If yes, state the problem or condition(s) you are being treated for:

Please list any medications you are currently taking, prescribed and over the counter.

Medication	Dosage	Prescribed and supervised by	Length of time taken

Primary Physician's Name:

I GIVE CONSENT TO CONTACT PHYSICIAN: ❑ Yes ❑ No Phone:

Physician Street address:

City:	State	Zip

HAVE YOU EVER BEEN HOSPITALIZED? ☐ Yes ☐ No If yes: ☐ Medical ☐ Psychiatric

Dates From / To	Reason / Incident	Location/Facility

HAVE YOU PREVIOUSLY SOUGHT COUNSELING / MENTAL HEALTH TREATMENT ASSESMENTS? ☐ Yes ☐ No If yes please list below

Disorder	Medications	For How Long?	Counselor	Helpful?
☐ Depression				
☐ Anxiety				
☐ ADHD				
☐ Bipolar Disorder				
☐ PTSD				
☐ OTHER				
☐ Substance Use Disorder				

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Name: DOB:

Family History: Please indicate any psychiatric problems that **may exist** among relatives **that are biologically related to you.**				
Disorder	**Mother**	**Father**	**Siblings**	**Other Biological Relative (specify)**
Depression				
Bipolar Disorder				
Suicide or Attempted Suicide				
Borderline Personality Disorder				
Anxiety Disorder				
Attention Deficit				
Schizophrenia				
Alcohol / Substance Abuse				

Do you have any problems getting to sleep? ❑ Yes ❑ No Please Describe

____

Any problems with appetite, eating, or gaining or losing weight recently? ❑ Yes ❑ No Please Describe

____

Do you have any allergies? ❑ Yes ❑ No Please Describe

____

Any history of head trauma? ☐ Yes ❑ No Please Describe

____

ABUSE HISTORY ❑ I was not abused in any way ☐ I was abused

ALCOHOL / CHEMICAL USE

Have you ever felt the need to cut down on your drinking or drug use at any point in your life? ☐ Yes ❑ No

Have you ever felt annoyed by criticism of your drinking or drug use? ☐ Yes ❑ No

Have you ever felt guilty about your drinking or drug use? ☐ Yes ❑ No

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Name: DOB:

Please indicate below any of the drugs or alcohol that you have used in the past 10 years

☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ PCP ☐ Inhalants

☐ Methamphetamine/Uppers ☐ Ecstasy ☐ Pills (please indicate) ______________________________

Have you ever had? ☐ Blackouts ☐ Bad reactions ☐ Withdrawal symptoms ☐ Overdoses ☐ Detoxification in a hospital

HAVE YOU EVER RECEIVED TREATMENT FOR CHEMICAL USE? ☐ YES ☐ NO					If yes please list
DATES FROM/TO	AGENCY/PROVIDER	VOLUNTARY (YES OR NO)	INPATIENT OR OUTPATIENT	PARTICIPATION IN AFTERCARE / TREATMENT	WAS IT EFFECTIVE (YES / NO)

LEGAL HISTORY

Are you presently suing anyone or thinking of suing anyone? ☐ Yes ☐ No If yes, please explain

____

____

Is you reason for coming to see me related to an accident or injury? ☐ Yes ☐ No If yes, please explain.

____

____

Are you required by a Court, the police, or a probation/parole officer to have this appointment? ☐ Yes ☐ No If yes, please explain.

____

____

Your current attorney's name and number if you are involved in a legal proceeding:

Name ______________________________ Phone ______________________________

Are there any other legal issues or Court proceedings I should know about?

____

If an assessment is to be presented to the Court, when is your next Court date scheduled? ______________________________

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Name: DOB:

List all criminal contacts with police, Courts, and jails/prisons you have had					
DATE	CHARGE	FEDERAL/STATE/ MUNICIPAL/COUNTY/ CITY	SENTENCE	PROBATION/PAROLE OFFICER NAME	ATTORNEY'S NAME

IN CASE OF EMERGENCY		
NAME OF LOCAL FRIEND OR RELATIVE		
RELATIONSHIP TO PATIENT		
I GIVE CONSENT TO CONTACT THIS PERSON REGARDING THE NATURE OF THE EMERGENCY ❑ Yes ❑ No		
HOME PHONE	CELL PHONE	
City:	State	Zip

FINANCIAL GUARANTOR (Person Responsible for Account)		
GUARANTOR NAME: (IF SELF, LIST SELF):		
Guarantor Street Address (IF SAME AS PATIENT, LIST SAME)		
City	State	Zip
Home Phone: Best Contact ☐	Work Phone: Best Contact ☐	Cell Phone: Best Contact ☐
Guarantor Email Address: Ok to contact ☐ Yes ☐No		Guarantor Social Security #

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Name: DOB:

CREDIT CARD TO BE KEPT ON FILE: ☐ VISA ☐ MC ☐ AMEX ☐ OTHER

CARD NUMBER____

NAME ON CARD____

EXP. DATE_________ SECURITY CODE: ________ BILLING ZIP CODE: _____________________

UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE, THIS CREDIT CARD WILL BE CHARGED FOLLOWING EACH APPOINTMENT AND / OR AT THE END OF ANY MONTH FOR WHICH THERE IS AN UNPAID BALANCE.
I UNDERSTAND AND AGREE THAT A LATE OF $25 WILL BE ASSESSED FOR ANY UNPAID BALANCE MORE THAN 30 DAYS PAST DUE

I agree to pay in full, at the time of service, for all services rendered on my behalf. I understand that Dr. Rafanello, CFPCS, LLC is ***not*** a participating provider with my insurance plan and is considered "out of network." CFPCS, LLC will provide a Billing Statement that I can file with my insurance provider for reimbursement. I understand and agree that payment for treatment is ultimately my responsibility.

I understand that 24 hours' notice of cancellation is required to avoid charges for missed appointments. I also understand that missed appointment fees are not covered by insurance plans.

The above information is true to the best of my knowledge.

PATIENT SIGNATURE *Date*

____

Date

PRINTED NAME

____

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE SIGNATURE *Date*

____

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